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Intercultural communication between Arabic speakers in Sweden as a microculture and the Swedish health care system as a macroculture in the context of healthcare

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FOREWORD

I would like to thank my mother and father for all their help with my children during the final writing of this thesis, as well as my family for all the encouragement and support, Imad and Souhaila for all your help with the thesis, Feda for your help with translation, the wonderful Doulas for letting me interview you and welcoming me at your workplace. I would also like to give special thanks to my supervisor Helene Kammensjö and my examiner Tetz Rooke. Thank all physicians, fantastic interpreters, and the people I met "on the way" that were willing to discuss this subject. Thanks to you all, it has been a pleasure to work on this thesis!

Very special thanks to my dear classmate Magnus Wennerholm for his kindness and support.

To the victims of COVID 19, those who left us and those who struggle with it. And to the healthcare professionals who support people all the time, without any limitations.

Abstract

Aim: This study aims to investigate the communication between Arabic speakers in Sweden as a microculture and the Swedish health care system as a macroculture in the context of healthcare.

Method: The study has both a qualitative and a socio-cultural perspective. It will be used as a theoretical tool to facilitate learning and development in communication to optimize the connection between Arabic speaking health care recipients in Sweden and the Swedish healthcare system. It was conducted by interviewing the professionals who work at the borders between the micro and the macro cultures in three significant roles: Arabic speaking healthcare professionals in different Swedish workplaces, *doula culture interpreters*, and oral interpreters. A total of twelve participants were interviewed in three groups, where each group consisted of four professionals. The interviews focused on how cultural differences in healthcare concepts and linguistics issues affect the communication between the two cultures.

Results: The results showed that differences in the healthcare systems between Sweden and Arab countries have significant effects on the Arabic speakers' health and understanding of the Swedish healthcare system in regards to treatment methods, speed of procedures, expectations, and decision making. Arab patients are vague in describing their symptoms to the doctor, and also have a massive stigma in regards to mental health. The communication barriers may extend to differences in dialects among Arabic speakers.

Keywords: intercultural communication, healthcare, Arabic, organizational culture, macroculture, microculture, Cultural Gap, Delivering Health Care

Contents

Problem approach

The number of asylum seekers in Sweden has increased dramatically in the last eight years. From around 30,000 per year at the beginning of the 2000s, it started to escalate in 2012 and reached a number of 160,000 asylum seekers in 2015. Many of them were people fleeing the war in Syria where the official language is Arabic (Sveriges officiella statistik, 2020). As a result, dozens of meetings in the medical sector take place in Arabic everyday throughout Sweden. The government has tried to find solutions to facilitate communication with non-Swedish speakers. The primary services that the Swedish healthcare system provides in this regard are interpreters, Arabic speaking physicians and healthcare providers, and *Doula cultural interpreters*—given that both cultures have their unique understanding of the concept of health and healthcare services. Also, Arabic speakers have different subcultures, dialects, and education that may affect communication during their interaction with Swedish health care providers. This raises many questions regarding macro-micro intercultural communication. In this thesis, I will investigate the cultural and linguistic aspects and their effect on communication in the context of healthcare.

Purpose

The purpose of this study was to investigate the communication between Arabic speakers in Sweden as a microculture and the Swedish health care system as a macroculture in the context of healthcare. It focuses on the cultural and linguistic aspects of communicating in Arabic in the case of physicians, doula, and interpreters providing their professional services to Arabic speaking patients. It aims to discuss the challenges that the microculture individuals experience, through the eye of Arabic speaking professionals in their position at the border between the Swedish healthcare system and Arabic speakers living in Sweden.

Research questions

- How do cultural differences in a macrocultural context (the Swedish health care system) affect communication with Arabic speaking patients?

- What are the linguistic problems that Arabic speaking professionals face, and what strategies and techniques do they use to solve these challenges?

- What are the differences between the healthcare systems in Sweden and the Arab countries that cause a kind of culture clash?

- What aspects may need to be considered as potential solutions for more effective intercultural communication in the context of health care?

1.Definitions

Intercultural communication happens across cultures and ethnicities when individuals from those groups interact. Their communication encompasses verbal and nonverbal messages (Neuliep, 2018, 44).

Culture refers to the way of life shared by a group of people—the knowledge, beliefs, values, rules or laws, language, customs, symbols, and material products (such as food, houses, and transportation) within a society that helps meet human needs. Culture provides guidelines for living.

Microculture is "an identifiable group of people that share a set of values, beliefs, and behaviors and possess a common history and verbal and nonverbal symbol system that is similar to, but systematically varies from, the larger, often dominant cultural milieu" (Neuliep, 2018: 163).

Macro culture is a dominant culture in a supposed context.

Organizational culture refers to "the values and behaviors that contribute to the unique social and psychological environment of an organization".

Interpreter is a person that enables communication between people who speak different languages, by orally translating what is said.

Cultural interpreter is a support person who has the language, the dual cultural competence, and the role of free interpretation. A cultural interpreter speaks the same language, and has the same origin, culture and tradition as the client. Additionally, He/She has knowledge in, for example; school's system, habilitation, social services, children issues, psychiatric issues (neuropsychiatric issues) special school, community orientation, healthcare, authorities, etc.… (folkhalsobyran, n.d)

Doula The word doula comes from the Greek language and means "woman who provides care". Women with experience of childbirth helping other women as they give birth is an ancient phenomenon. A doula is a person who acts as support during labor and delivery. She has cultural competence from both her country of origin and from Sweden, she is familiar with Swedish maternity care and provides support in the language spoken by the woman giving birth (Doula, 2020).

Classical Arabic is the standard language used by the Arab people who lived before Islam, it's also used in Quran and throughout the Arabo-Islamic period (Versteegh, 2004: 1740-1741).

Modern standard Arabic is a modernistic form of classical Arabic and differs by its phraseology and lexicon in addition to syntactic adaptation (Versteegh, 2004: 1740-1741).

Arabic dialects are called "common, vulgar language (ᶜāmmiyya)" the languages that used after the occupation period. they are considered being the colloquial form of the Arabic language and the opposite of the "correct- classical language (al-fuṣḥā)" (Versteegh, 2004: 1740-1741).

2.Introduction

"The effect of cultural systems of values on health outcomes is huge, within and across cultures, in multicultural settings, and even within the cultures of institutions established to advance health. In all cultural settings—local, national, worldwide, and even biomedical—the need to understand the relation between culture and health, especially the cultural factors that affect health-improving behaviors, is now crucial. In view of the financial fragility of so many systems of care around the world, and the wastefulness of so much of health-care spending, a line can no longer be drawn between biomedical care and systems of value that define our understanding of human wellbeing" (Napier, et al., 2014).

This research is based on the premise that health is understood in cultural terms beyond measures of clinical care and disease. Different cultures and societies understand health in different local ways, even though global definitions and paradigms still stand. The relationship between these two formulations is not oppositional. Integrating the local, national, comprehensive, and biomedical understandings of health is important in any cultural setting as it improves health services and behaviors. The gap between the objectivity of science and subjectivity of culture distorts perceptions of healthcare for both the providers and the patients. This is especially pertinent to large communities with different microcultures as in Sweden (Napier, et al., 2014).

Sweden is a multicultural country; it has a large number of citizens with an immigrant background. Arabic is one of the major world languages. The usage of the language throughout the Arab world is characterized by diglossia, i.e. competence in both the conversational language and Modern Standard Arabic (MSA). Classical Arabic is the language in which the Quran is written. Standard Arabic, or MSA (Modern Standard Arabic), is a variety of Arabic language derived from the Quran and is the common written language for all Arabic-speaking countries. In spoken form, it is used primarily in religious and political contexts. Dialectal Arabic refers to the regional varieties of Arabic. It is the language that Arabic-speaking people learn at home and is spoken in all environments and at all levels of an Arab society (Versteegh, 2004: 1740-1741).

The last armed conflicts in the Arab world, especially in Iraq and Syria, has contributed to a surprising increase in the number of Arabic speakers in Sweden. This situation has revived the phenomenon of microcultures in the Swedish society. The rapidly increasing number of Arabic speakers in Sweden became a challenge to the Swedish government and other authorities in the country, especially to the schools and the health care system. In Sweden, huge efforts need to be made to provide equal care to everyone regardless of their cultural background. The government tried to find solutions to facilitate communication with non-Swedish speakers. The main services that the authorities provide are interpreters, Arabic speaking physicians and health care providers, Doula kulturtolk (cultural interpreters), Arabic speaking teachers, and Arabic speaking school supporters.

Patients can be divided according to their language proficiency, into three different levels: patients who do not speak the language at all; patients who speak the language, but have very deficient language skills; patients who can speak the language, but who cannot nuance it. When patients cannot speak the language and the interpreter is not used, the meeting with the care staff can be traumatic for the patient. Studies show that older immigrant patients have the greatest language barriers, as well as the group of immigrant women (Gerrish, 2001).

In this study I will explore communication in two cases:

1- where both the healthcare professional and the patient are Arabic speakers while communicating within the framework of the Swedish healthcare system.

2- Where the healthcare professional and the patient speak different languages and use an interpreter as an intermediary for communication.

In the first case, the communication between patients and health professionals that speak the same language is demonstrated immediately. However, we should take into consideration that how language is used, play an important part in physician-patient communication. As Sundquist (1995) indicates, the use of specialized terminology, focus on medical uncertainties, and the failure to adjust to patient limits and concerns may all affect doctor-patient communication even if they speak the same language (Sundquist, 1995)

When interpreters are used in meetings, the conditions can vary depending on what language is used. They also depend on many other factors, such as the interpreters' qualifications, the culture of each

party and the metrics of the healthcare system (limited meeting time, treatment methods, queue system, etc.). In Sweden, interpretation of Arabic dominates in many contexts. However, the statistics do not represent the variations in the language due to different dialects and, as a result, the need for different types of interpreters. We can get an overview of the status of Arabic interpretation in SOU (2018) "Att *förstå och bli förstådd: Ett reformerat regelverk för tolkar i talade språk*" (2018:83). The investigation has gained insight into the variety that may exist for different language groups, geographically and over time regarding the needs and usage of interpretation services. The authorities' assessment found that in many county councils, Arabic alone accounted for more than half the interpretation orders. Yet there is still a lack of available Arabic interpreters. Patients with interpretive needs tend to avoid seeking treatment due to a lack of trust and long waiting periods for interpretive care appointments. Patients are rarely asked what dialect they speak, or if they have specific requests for an interpreter (SOU 2018:83)

Arabic speaking patients prefer to meet an Arabic speaking doctor. Therefore, those doctors take large patient boards. The Arabic speaking patients have also started to seek alternative ways to get in contact with Arabic speaking doctors.

Thus, the telemedicine industry in Sweden (with companies like the KRY app, Daqatra, and Doktor.se) became interested in providing more Arabic speaking physicians. The interaction between the physician and patient using the webcam interface has been only recently started to be used as a method of care delivery. These services cost the Swedish healthcare system more money than regular visits, which leads to increasing costs and decreasing trust between the Arabic speaking patients and the public healthcare system.

In ten years, the number of nurses and doctors who have moved to one of the 38 OECD countries is estimated to have increased to 60 percent. Doctors born abroad now account for almost a third of all the doctors in Sweden (Lindahl, 2015, 22 september)

Researchers in the field of healthcare focus on immigrants' communication with Swedish health care professionals, but rarely on Arabic as a specific language or the communication between Arabic speaking health care professionals and Arabic speaking patients.

3.Theoretical background

"Intercultural communication is a symbolic, interpretive, transactional, contextual process, in which people from different cultures create shared meanings" (Lustig & Koester, 2010: 46).
The concept of intercultural communication describes a cultural meeting in which communication takes place with someone or something different and foreign. Intercultural communication (as described in this study) is not only used between individuals and groups, but also between organizations and societies. The word culture usually refers to national/transnational contexts such as Swedish/Arabic culture. More recently, intercultural communication has expanded to include organizational cultures, urban and rural cultures, and cultures of regions, generations, and professions. Many factors contribute to making the communication between two cultures more challenging, such as differences in values, norms, meanings, distances of power, time perception, symbols, the importance of context, and the degree of individualism and collectivism. Intercultural communication presents the potential of "cultural clashes" (Nationalencyklopedin, n.d).

The research on applied linguistics and intercultural communication is built on numerous disciplinary foundations. Early efforts of this collaboration can be traced back to the early eighteenth and nineteenth centuries. Between 1930 and 1940, the work of American anthropologists such as Ruth Benedict, Clyde Kluckhoh, Gregory Bateson, and Margaret Mead, procured important suppositions that built the foundation of intercultural communication studies in the United States. Ideas such as considering the individuals within national boundaries to hold a certain group of beliefs and features, and how a person's perception of the world can be affected by the different ways that languages encode cognitive and cultural denominations, became basic notions in the research of languages and intercultural communication. The collaboration of linguists and anthropologists produced the subdiscipline of intercultural communication that was consolidated in the mid-twentieth century. The interdisciplinarity that produced this subfield has been crucial to how people explore how to communicate more efficiently across cultures. While anthropology focuses on the structures of economics, regions, government, and kinship and produces macro-cultural narratives, microcultural studies have a different genealogy (Martin et al., 2012, 18-19).

3.1 Macroculture and microculture

This chapter contains a literature overview to describe the meaning of the terms macroculture and microculture, and why we use these terms to describe the Arabic speakers in Sweden and the Swedish healthcare system.

Small cultural groups have always had a place in sociolinguistics and anthropological studies. Most cultures in the world include groups (subcultures, co-cultures, or minorities) that differ from the general macroculture in a significant way. The concept of microcultures was presented by Edward T. Hall—who is recognized by many as the "founding father" of the formal study of intercultural communication interested in the unconscious aspects of cultural behavior. Hall's notions of proxemics consider the human use of space to be cultural. This is important because it has implications for intercultural communication as a space that we approach with unconscious cultural behavior. The proxemic, with its three levels of the infracultural, precultural, and microcultural, can be seen in communication processes and culture-infused environment design (Martin et al., 2012, 19).

Microcultures have also been theorized in sociology. I am specifically referring to Ballantine, Roberts, and Korgen's book "Our Social World: Introduction to Sociology" where they introduce the social world model in which they divide social groups into three analytical units: the macro-level, meso level or subculture and the micro-level or microculture. The order goes from the largest to the smallest, where the macro level can be the global community, nations, or global cultures. The subculture can be ethnic groups or institutions and the microculture can be local parts of the institutions or even the interpersonal space (Ballantine et al., 2018: 101). The scale is the guiding measure of structuring an analysis that follows this division. Organizations, institutions, and ethnic communities are situated in the meso-level of analysis because they are of intermediate size, meaning that they surpass everyday personal experiences of individuals and do not foster relationships that connect each of these individuals, yet they are still smaller than nation-states and regional communities. A micro-level analysis can zoom in to one-to-one or small group interactions. This is important because these interactions are the building blocks of all social groups and organizations, and we experience the families, corporations, societies, and nations we belong to through our relationships ((Ballantine et al., 2018: 101, 102).

Finally, a macro-level of cultural theories integrates the above by focusing on large social units such as the institutions of the family, education, religion and healthcare, nation-states such as Canada or Mexico, and global systems such as the World Bank or World Trade Organization. Micro-level studies can reveal important mechanisms and trends that also act on the meso- and micro-levels. Micro-level social units differ from meso- and macro-levels in their temporality. Microcultures have short-term impacts, and people are part of them only in a specific aspect or for a relatively short period, e.g. college societies or a business office ((Ballantine et al., 2018: 131).

Subcultures can also be distinguished from macro- and microcultures by the ability to sustain themselves and support their members for as long as a lifetime, without being as large as, for example, nation-states. This is why ethnic groups are considered to form subcultures defined by the set of cultural conventions and expectations (Ballantine et al., 2018: 234).

Pic: (Ballantine et al., 2018: 235)

Table 3.5 Level of Social Units and of Culture

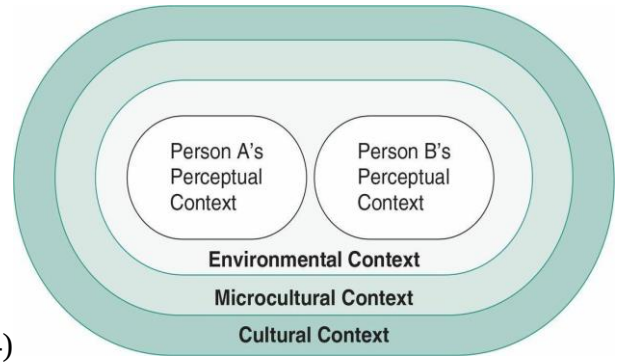
Social Unit (People who interact and feel they belong)	Culture (The way of life of that social unit)
Dyads, small groups, local community	Microculture
Ethnic community or social class community	Subculture
National society	Culture of a nation
Global system	Global culture

In his book “Intercultural Communication: A Contextual Approach” (2018), Professor of communication and media studies James W. Neuliep presents “The Contextual model" as a way to examine communication within cultural and perceptual contexts on different levels. The model includes the cultural, microcultural, and environmental backgrounds of the interactants. The unique personal psychological perspective of each interactant also plays a role in how communication plays out. When two people communicate across their different cultures, they try to connect these contexts. They share the ability to take in, store, and retrieve information, but the way they do these things is influenced by the same cultural, microcultural, and environmental contexts of communication (Neuliep, 2018: 265).

The model is conceptually and graphically consistent with the cultures in question. The first

considerations are of cultural values, beliefs, and behaviors. Microcultural considerations of the diversions from the larger cultural milieu follow (Neuliep, 2018: 163). Neuliep mentions that microcultures differ from the macrocultures or the larger cultures because of language, ethnicity, religion, race, or behavioral practices (such as gay, lesbian and bisexual communities that can form some kind of microcultural group). A significant communication technique used by microcultural groups is the development of a communicating language for interactions outside the majority culture or macrocultural context. Microcultural groups often have less power than the macroculture. In other words, groups who have the most power in society are considered as the majority or dominant group; this power can be political, legal, religious, or even economic, and it is not related to the group size (Neuliep, 2018:164).

According to Schaefer, we recognize the minority groups by the power and the control that group members have over their lives. The physical, sociorelational, and perceptual environment play an important part in this context, because our perception of the environment depends on our membership in cultural and microcultural groups (Neuliep, 2018:118). Finally, the individual characteristics of each interactant, like their cognitions, attitudes, dispositions, and motivations, affect communication as well. This is called the perceptual aspect, since it deals with how an individual gathers, stores, and retrieves information (Neuliep, 2018: 256).



Pic: (Neuliep, 2018: 264)

3.2 Health care as a macroculture

"Organisation is an organized group of people with a particular purpose, such as a business or government department" (Oxford learner's dictionaries, n.d).

The idea of considering the health care system to be a culture is related to the concept of organizational culture. According to the *Oxford Dictionary of Organizational Behaviour,* the term organizational culture refers to "a product of factors such as the organization's history, founders, its sector, nature and type of employees, technology, the physical environment, organizational strategy, management practices, and national culture. It is evident in its mission statement and vision, espoused values, symbols, norms, selection of and behaviour of employees, the location and design of physical space, stories, and use of language" (Jeanes, 2019)

According to a recent article in Harvard Business Review, the common beliefs, behaviors, and values of organizational culture are enacted by the people within a company. They appear in the employees' performance, customer service, co-operation, motivation, and sincerity to the company's mission. The way they work together and their feelings about their tasks and the company are all part of the organizational culture (Groysberg et al., 2018).

Studies on organizational culture have been conducted since the 1940s, but the 1980s saw a 'corporate-culture boom' before which organizational cultures were sparsely studied. The decade that followed was rich with interest from practitioners in the study of organizational cultures, and it was connected to the industry. Another distinction remains between the practitioners of young, innovative, and knowledge-intensive businesses and mature rationalization-oriented businesses in that the former has shown more interest in the field (Alvesson, 2002: 6).

Edgar Henry Schein is a renowned professor at the MIT Sloan School of Management, who studied extensively in the field of organization management. Schein (2010) mentions that organizational cultures exist in context. Some assumptions characterize the whole organization, called the corporate culture in private organizations, and a set of assumptions characterize subunits of the organization. These subcultures reflect the functional units, the rank levels in the hierarchy, isolated geographic

units, and any other groups that have a shared history. As organizations evolve in the global context, there will be more emphasis on multicultural teams that can be considered to be microcultures. How such microcultures are created and how they relate to other microsystems with different microcultures will be an important field of study for the future (Schein, 2010: 22).

Two things inspired me to use the term "macroculture" to describe the Swedish healthcare system. The first one is the field of my study in the context of healthcare, and it focuses on the clash between two health cultures in Sweden, where logically the Swedish one is dominant.

The second point is what Schein indicated: how some big systems or organizations in society can be considered to be macrocultures, yet their power is limited to their impact area. He mentions that occupations, such as medicine, law, and engineering, transcend organizations and, for some purposes, can also be thought of as macrocultures, yet their main impact is in their operation as subcultures within organizations (Schein, 2010: 22). The healthcare system in Sweden is a big organization that has its system, beliefs, values, and has its own philosophy and treatment methods.

Two things support the perception of the Swedish healthcare system as a macroculture:

1- Healthcare in Sweden is a tax funded governmental institution, and private healthcare is very limited. The Swedish Association of Local Authorities and Regions has made a knowledge overview of Sweden's efforts to provide healthcare on equal terms and presented it in the report “Vård på (o)lika villkor – en kunskapsöversikt om sociala skillnader i svensk hälso- och sjukvård”. The report mentions that the Swedish healthcare system is highly ranked internationally, thanks to the high competence and morale that is shared by its employees. This is backed up by the fact that, according to Statistics Sweden, a majority of the population strongly believes in healthcare institutions. In Sweden, public funding dominates health care, while private healthcare companies and insurances have a minor share of the sector (Sveriges kommuner och landsting., 2009)

2-The healthcare sector is crucial to the national economy as it employs the greatest number of employers in Swedish municipalities and regions (about 79% of employers in Swedish regions) (Sveriges kommuner och regioner, 2019: 10).

3.3 Arabic speakers as a microculture

Microculture refers to the idea of a smaller culture or a sub-culture within a culture. A culture reflects the majority of the population, whereas a microculture reflects a smaller group of individuals. By definition, microculture refers to the specialized subgroups marked with their languages, ethos, and community governing expectations. Microculture also refers to the smallest groups or local communities as opposed to the broader subcultures of race or class and wider national/global culture.

Microcultures represent systems of social cognition features of subgroups within larger societies. Members of the microculture can usually share more of what they learn with everyone in (the higher world) but can have limited social knowledge that is unique to this group. For instance, the college society is a microculture within the context of a university and of the country. It is the shared knowledge that makes up their microculture and this will serve as the foundation for ethnographic learning (Neuliep, 2016: 60-61).

The number of foreign-born people in Sweden has increased in the 2000s. For example, in 2000, the number of foreign-born was 1,003,798, and the proportion was 11.3 percent. At the end of 2019, there were 2,019,733 people, and the proportion was 19.6 percent. There are no official statistics in Sweden on the number of speakers of each language, but the statistics on the immigrants' countries of origin show that the most common country is Syria, followed by Iraq (totally 337,578 population for Syria and Iraq). Both countries have Arabic as their official language (Sveriges officiella statistik, 2020). These numbers can give us an approximate perception of the number of Arabic speakers in Sweden, considering that there are other minority languages in these countries. Also, other countries on the list have Arabic as a second language, minority language, or religious language, e.g. Somalia, Eritrea, Afghanistan, and Iran. For many years Finland has been the most common country of birth for foreign-born in Sweden, with immigration since the 1940s, but as they grow older, the number of Finnish-born is declining. According to the latest statistics, Finland is now only the third most common country of origin for foreign-born (Sveriges officiella statistik, 2020). As a result, it can be said that Arabic is now the second most common language in Sweden.

Sweden has had five official minority languages since 2000, namely Finnish, Meänkieli (Norrbotten

Finnish), Sami, Romani, and Yiddish. These languages have special rights that implemented in the Swedish minority policy, such as educational, cultural, and anti-discrimination measures (Ministry for Integration and Gender Equality, 2007). The Arabic language in Sweden is an immigrant language so the speakers don't have the same rights as minority languages.

The other thing that inspired me to use the term "microculture" to describe Arabic speakers in Sweden, is that in Sweden it is easy to be identified as an immigrant based on your outer appearance and language. In their report to Integrationsverket, Nekby and Rödin (2007) indicated that cultural identity is a concept that describes the connection between the feeling of belonging to the ethnic background culture and the Swedish majority culture. They mentioned that outer appearance and skin color play a part in immigrants' identity. Those with non-European backgrounds are to a greater extent" noticeable immigrant" due to their skin color, atypical surnames, and other attributes that signal e.g. jobseekers' ethnic backgrounds but not their identification with the majority culture. Those elements combined with other factors lead to the phenomenon of mini-communities described by Holgersson (2011). When people with equal ethnicities settle close to each other, areas with homogeneous ethnic groups are created. This gives rise to the formation of environments in the form of strong associations that differ in one way or another from the rest of society. In these areas, some people blend in better than others. Correspondingly, those who do not feel that they fit in in that environment can experience exclusion from it. These associations can largely be based on the social factors that separate people from each other. Factors such as a particular religion, skin color, class, culture, language or ethnic background can be crucial to people's living conditions. These social circumstances can contribute to some people intentionally excluding themselves from the remaining society. This conscious exclusion is called ethnic housing segregation, with strong ties between the individual himself and the geographical establishment of housing (Holgersson, 2011: 98-112).

3.3.1 Variation in Arabic

Arabic is considered to be the official language in twenty-three countries. The communities of such countries have been labeled as diglossic speech communities, where two varieties of the same language co-exist. Usually, the official language is written Arabic (*fuṣḥā*), but each country often uses at least one dialect.

Versteegh (2004) explains the different types of Arabic language:

- Classical Arabic is the Arabic language that was used in the pre-Islamic period and the Quran. It is still used as the standard language throughout the Arabo-Islamic period.
- Modern standard Arabic is a modern form of classical Arabic and differs by its phraseology and lexicon in addition to syntactic adaptation.
- "Arabic dialects" are the colloquial language used after the conquests period. It is also called "common, vulgar language (*ᶜāmmiyya*)" and is considered to be the opposite of the "correct- classical language (al-*fuṣḥā*)".

fuṣḥā and *ᶜāmmiyya* as end posts in a "continuum of speech variation" would be an ideal case of diglossia (Versteegh, 2004: 1740-1741). According to Bassiouney, Arabic should be observed from two axes: a vertical diglossic one and a horizontal one concerned with local varieties and different dialects (Bassiouney, 2009: 9,10). Diglossia, as described by Versteegh (2014), means that there is both a "high" or prestigious language and an everyday language that people use in different situations. The official Arabic language is the written Modern Standard Arabic (*al-ʿarabiyyah al-fuṣḥā*) used at official political meetings, in the media, and at meetings between Arabic-speaking people whose dialects differ so strongly that they communicate in the standard language. The everyday language is the spoken dialects (*ᶜāmmiyya* or, in North Africa, dārija). These Arabic dialects differ significantly from the standard Arabic in terms of syntax, vocabulary morphology, and phonology. The dialects impact the standard language whenever in practice. There is often an overlap in a continuum between the "dialects" and the "standard language" (Versteegh, 2014: 241-243). Arabic dialects differ from Standard Arabic and from each other. They are very varied to the extent that when an Iraq and a Moroccan have a conversation in their dialect, they will probably not understand each other. But those dialects still share some features contrary to Classical/standard Arabic (Versteegh, 2014: 133). According to Versteegh, the traditional classification of the Arabic dialects differentiates the following geographical groups, where each dialect group is also divided into subgroups:

1. Dialects of the Arabian Peninsula
2. Syro-Lebanese dialects
3. Mesopotamian dialects
4. Egyptian dialects
5. Maghreb dialects (Versteegh, 2014: 189).

As described above, Syria and Iraq are the most common countries of origin for Swedish immigrants. Syria belongs to the Syro-Lebanese dialects whereas Iraq belongs to Mesopotamian dialects. According to Versteegh, the Syrian dialect is one of the best-reached dialect areas in Arab countries (Versteegh, 2014: 218). It is important to note that any dialect's division is a kind of arbitrary work because the linguistic borders are inconspicuous. In addition, there is a kind of dialect continuum, where the dialects don't have sharp borders, but they change gradually from the community to the community. For example, on the borders between Syro-Lebanese dialects and Mesopotamian dialects, we can find many communities speak dialects that share features of both kinds (Versteegh, 2014: 172-176).

4. Challenges on each level

Understanding that culture and its impact is necessary to improve healthcare. As a result, today disciplines concerned with the study of society largely focus on health issues. Nowadays, medical and anthropological studies of the human wellbeing are key to revisiting the way society conceptualizes what is healthy and what is not (Napier, et al., 2014).

In the next two chapters, I will present the challenges and circumstances that, according to previous studies, play a role on each level and in some way affect the communication between the different parties.

4.1. Challenges on a macrocultural level

The official health care guide website in Sweden (1177.se) indicates that today, health care services are not equal. Some patients are given the same quality of care while some receive less advantaged care. The website states that equality is a main principle to provide proper healthcare services that are catered to every patient based on their condition and needs, regardless of their ethnicity, gender, race, orientation, or background. Yet, there are many reasons behind inequality in access to care. Such reasons are often related to regional, language, physical, and discriminative factors. Personal lifestyle and mode of self-care significantly affect human health. Although general health has improved in the population, mortality and morbidity varies in Sweden according to gender, age, region, social groups, and citizenship. It also differs between Swedes and other foreign citizens (1177, 2018).

Economic and systemic issues are significant in healthcare systems. The Swedish Association of Local Authorities and Regions (SKR) has published a report that mentions bureaucracy and mismanagement of resources as obstacles in the Swedish system. The report claims that patients' choices of who would provide them with healthcare, and where, have been significantly restricted. Traditionally, the Swedish healthcare system and its apparatus have been budget-controlled. Some parts of the system have been overly dependent on bureaucracy and central planning. There is a lack of research that relates the financial status of the healthcare system to its performance, and as a result,

there is an absence of financial support initiatives that would increase efficiency. An additional aspect of budget-driven management is how the dynamics between patients and healthcare providers affect the received quality of care. In many cases, some patients do not receive proper healthcare services because of mismanagement of resources by healthcare providers (Sveriges kommuner och landsting., 2009)

Further details can be found in a report from Myndigheten för vård- och omsorgsanalys. The number of expenditures covered through patient fees and payments is very low. At the same time, there are few financial incentives to limit medical expenses. Healthcare providers generally do not pay attention to the costs of the care they provide. The patient usually prefers to be provided with the healthcare they think they need in one setting. The medical staff have no financial incentives, such as limiting tests, X-ray scans, and referrals, since the cost will not directly cover their budget, but will be funded by other sources. So-called third-party issues arise when one party consumes services, another produces them, and a third party is responsible for financing and struggles with this while impacting the behavior of consumers and producers. An additional struggle is related to how municipalities and county councils exchange responsibilities due to economic reasons. This process is specifically prevalent in healthcare issues that is also related to social services, e.g. psychiatry, drug abuse, primary care, and nursing care (Myndigheten för vård- och omsorgsanalys, 2018).

Confidence is another significant factor that has a direct effect on healthcare services. The report mentions that the basic precondition for a well-functioning health and medical care system is that the population feels confidence in the care given. The degree of trust affects both the efficiency of care at the system level and, in the long run, the health of individuals. Confidence is still shaped by elements that are both within and outside the control of health care. A patient and citizen perspective on how healthcare works is an important basis for trust which, in turn, can be influenced by health care decision-makers. But besides the economic and political context, we have to consider that the factor of an individual's characteristics and attitudes at the societal level also affect trust. The perception of care is also related to the information and knowledge basis which the individual has access to and considers credible (Myndigheten för vård- och omsorgsanalys, 2018)

All these aspects and details are not known to the Arabic speaking patient. As a result, it can affect the way they perceive the Swedish healthcare system and the way they judge and interact with it.

4.2.Challenges on a microcultural level

According to Socialstyrelsen (2008) and Statistiska Centralbyrån (2006), the Swedish Health Care Act that was adopted 20 years ago stresses equal access to good healthcare. The overall goal of this policy is to provide good health and care to all people, equally. Research shows that immigrants are not satisfied with medical care in Sweden. They prefer not to ask for medical help and are usually unsatisfied with the care they receive compared to the rest of the population. Gaps in medical services also cause problems when it comes to drug prescription for immigrants and people with lower-income, in health issues related to heart attacks and heart failure, as well as chronic obstructive pulmonary disease (Västra Götalandsregion, Folkhälsokommitten, 2009).

The challenges that affect microculture individuals have two sides. The first one is regarding their situation in a foreign country (Sweden). The second one is related to the beliefs and health culture that they developed in their country of origin.

The challenges they face in Sweden are described by Dr Sofie Bäärnhielm, consultant and unit manager in the transcultural Center, and Dr. Anna-Clara Hollander in an article in Läkartidningen. Here, they discuss how social determinants of health affect everyone. The health of foreigners is heavily impacted by other factors, such as the refugee experience, duration spent in the host country, linguistic skills, social circles, the distorted sense of identity, and adaptation to new social circumstances and cultural norms. They also talk about the "ignorance" of available healthcare opportunities and obtaining such chances. To solve this problem, a new professional community of health communicators was formed. They carry out preventive measures to improve the health of refugees and immigrants, but also communicate and stay in contact with medical institutions. Also, they highlight the difference between the disease panorama used by immigrants and the cultural expression of disease (Bäärnhielm & Hollander, 2015,18 August)

To understand the immigrants' culture of health and its effect on their life, health, and communication with other cultures and healthcare systems. An interesting explanation can be found in the two following studies:

- A study conducted by Laughlin and Braun on potential areas of conflict between the more collectivist values of Asian and Pacific Islander cultures and the more individualist orientation of the U.S. healthcare system. All cultures have a health belief system that explains the origins of disease, treatments, and concerned participants who should be involved in this process. The willingness of patients to receive patient education increases when such awareness is made culturally relevant to them. Western industrial countries, like the US, regard illnesses as the result of biological and scientific phenomena, and therefore promote medical treatments or employ complex technologies in the process of diagnosis and treatment. In other cultures, diseases result from supernatural phenomena and divine intervention, and thus advocate for spiritual practices, such as prayers, to combat such disfavors from the divine. Hence, cultural factors are key when it comes to patient compliance. Research proved that a group of Cambodian adults of a minimal formal education showed remarkable efforts to go hand in hand with treatment, but did so only in a way that is homogenous with their acquired understandings of medications and how the human body works (McLaughlin & Braun, 1998)

- A study on Patients' Transcultural Needs and Carers' Ethical Responses published in *Nursing Ethics*, conducted on Turkish patients in Germany and Germany's health care providers. The authors summarize the culturally relevant challenges in the field of health care:

- The conception of disease: The meaning of health and disease is not elaborated on in all cultures, because such meanings are part of daily life. Illness is seen as a valuable concept, and diseases and health conditions are not necessarily or inherently medical concepts managed by treatments; they are cultural phenomena as well.

- Responding to and Coping with Disease: To help patients recover from disease, health professionals need to be aware of the patient's definition of the disease, while helping them abide by the treatment. According to a nurse in a German hospital, ten nurses faced significant problems when dealing with foreign patients. This was due to the gap between the cultural understanding of health and disease concepts in Germany, and these patients' conceptualization of the German culture and healthcare system. One of the root causes of these problems is the medical staff's poor adaptability to the new culture and ethnic background, leading to prejudice, stereotypes, speech, and behavior, influenced by cultural chauvinism and giving patients with a foreign background a feeling of guilt. Such judgmental attitudes result in a low quality of healthcare through nurses complaining about foreign

patients. The staff would also refrain from encouraging the patient to use their cultural conceptions and resources to cope with the illness. This leads to patients poorly coping with their diseases and hence no dedication to abide by treatment plans. Residing in a foreign country that has different traditions, norms, and lifestyle than one's own country presents a multifactorial challenge for immigrants and refugees.

- Judgments, discrimination, and values: Multiple values are seen to be the constituent features of modern society. In all societies, the cross-cultural doctor-patient relationship is an important part of daily medical practice. The value system determined by culture is essential for understanding concepts such as "health" and "disease" and leads to essential variations in the evaluation of medical interventions and treatment goals. Different values bring about significant problems, such as judgmental prejudices and discrimination against different cultural norms, and conflicts between shame and religious responsibilities, which may lead to serious moral dilemmas within medical and healthcare practice (Dogan et al., 2009).

4.2.1 The Arabic interpreter

While previous chapters have discussed patient-healthcare issues, this chapter will look into the case of using interpreters as an intermediate of communication. There are two interpreter services that Swedish healthcare provides for patients who can't speak Swedish: oral interpreter and Doula cultural interpreter. These two kinds of interpreters are two of three groups that will be interviewed in the study later.

According to Tolkutredningens report from 2018, there has been an increasing demand for interpretation services by several governmental entities working with public sector efficiency, legal security, and comprehensive integration policy and development. The changing demographic conditions in Sweden will increase the demand for interpretation services in the long term. While there has always been a need for interpretation on several occasions, the boom came with the increase in the number of asylum seekers in 2015–2016. This prompted questions regarding how more high-quality interpretation services can be made available. The legal basis for the demand is the Public Administration Act's requirement for interpretation on specific occasions. The demand has been supported by the public sector, private and public interpretation services, and around 5-6,000

independent interpreters so far. The high demand is largely met even though most interpreters do not have the authorization or training. The interpretation sector costs approximately 2 billion SEK per year (Tolkutredningen, 2018). A report presented by Learnings Center Migration and Health (2019) in 2019, regarding interpretation in Swedish health care, describes the factors that affect the usage of interpreters in health care. The usage in healthcare is determined by several factors including, but not limited to, time restraints for the staff, poor access to interpretation services, and the staff's low awareness of these services, even when available. The time factor has two aspects, where staff might not have time to schedule appointments with interpretation and such appointments take longer than usual care meetings. Despite the hindrances, it is vital for patients and healthcare professionals to communicate effectively (Kunskapscentrum migration och hälsa, 2019).

A cultural interpreter is "a person who has the same language, origin, culture and tradition as the client. The cultural interpreter interprets signals from a cultural perspective, has the same frame of reference as the target group, which creates the conditions for a good dialogue" (folkhalsobyran, n.d). They work at a family center, child care center or midwife clinic. Their mission is to inform the immigrants they help, about cultural differences how Swedish society works. The information they give are about parental benefit, population registration, children's rights, maternal and child health care, vaccinations, equal parenting and what to do when a child becomes ill (regionvarmland,2020). The cultural interpreters have a freer role than the oral interpreters, because they don't translate the conversations literally. They are informants who provide the cultural and linguistic aspect of the conversations and measures; thus, they translate everything said in the conversations based on the linguistic and cultural context, with the goal that the information is understood by all who participate in the conversation (folkhalsobyran, n.d).

Usually, the same persons who work as a cultural interpreter, work also as doula cultural interpreters. Because in many schools they have the same courses or consecutive courses to teach this profession. Besides that, working as a doula is not a stable job and is not enough to create an income. They also work in areas populated by immigrants, so they create relationships with them, which allows cultural interprets to translate a person's speech based on his personal knowledge of him/her.

The official website of Doula culture interpreters motivates the importance of doula's support that women born outside EU countries experience more difficulties and complications while giving birth

than do Swedish-born women. As a result, the children of women from outside EU countries are four times more likely to die in childbirth. The overrepresentation of such complications for these women as a group is considered a result of poor communication between the women and the maternity healthcare staff. Poor communication does not refer to linguistic differences alone, but also to cultural ones that create misunderstandings, mistrust, and insecurity. Women from other countries end up receiving less safe care, which impacts their and their children's health (Doula & Kulturtolk, 2015). This plight is being tackled in a pilot project called "Foreign-born women as doulas and cultural interpreters" which is a collaboration of the association Födelsehuset and the public health committee in Västra Götalandsregionen. This project is an attempt along the lines of the public health goal "to create social conditions for good health on equal terms for the entire population" through new methods that preserve the health of foreign-born mothers and provide them with safer care. The project trains women who are native speakers of the major immigrant languages to become doulas; a healthcare employment where women provide support to other women before, during, and after childbirth (Västra Götalandsregion, Folkhälsokommitten, 2009).

5. Previous research

Many studies have been conducted in the field of healthcare and cultural beliefs. In this chapter, I will present a review of some of this previous research. The first and second studies are conducted on Arabic-speaking participants, whereas the participants in study 3 are African-born women that may to some extent be Arabic speakers. This study is also an example of the impact of cultural beliefs, which is one of the focuses of this thesis. The fourth one is conducted in Sweden about language barriers.

-“Collaborative Partnership for Culture Care: Enhancing Health Services for the Arab Community” The study used a qualitative focus group method on three groups: healthcare system administrators, Arab Americans, and nurse researchers. The study aimed to explore the impact of the healthcare system’s complicity on Arab patients, the communication that prevents culturally competent care and accessible services, and the caring behaviors of Arab patients and their opinion about cultural competency. The findings indicated:

- a lack of awareness among healthcare providers about the cultural and religious related values and other issues, such as gender, behaviors, and the role of the family
- a lack of knowledge among Arab Americans about the healthcare system, which in turn created communication barriers
- variances in perceptions of cultural competence between Arab patients and healthcare providers, showing how important accessible healthcare and cultural acceptability is to improve communication
- recommendations to develop programs to facilitate the accessibility of health services for recent Arab immigrants, where patient information and literature in Arabic is provided, as well as develop a health promotion campaign to raise health awareness among Arab communities in the USA and employ bilingual providers and Arabic English translators, especially in the “front line” (Kulwicki et al., 2000)

-” Exploring the Health Care Challenges and Health Care Needs of Arabic-Speaking Immigrants

with Cardiovascular Disease in Australia”

In Australia, Arabic speaking migrants make up the fourth largest language group. They also have a high incidence rate of cardiovascular diseases (CVD). The aim of this study was to explore the healthcare needs and challenges of Arabic speaking CVD patients. The researchers compared 15 patients from this group with 14 English speaking CVD patients. The findings showed that Arabic speaking CVD patients have a wider range of healthcare needs and challenges. Their needs comprise more effective healthcare providers-patient communication, accessible care, and patient empowerment. Meanwhile, a few of the English-speaking patients mentioned the same healthcare needs as “unmet” needs. The study suggested that Arabic speakers' patients need a health care model that respects their necessity for assured privacy and healthcare provides-patient communication to adapt their health literacy and English proficiency. They also need physician-pharmacist collaboration by interference for example pharmacy-based CVD management services (Abdelmessih et al., 2019)

-A study conducted by Hjelm, Berntorp, and Apelqvist regarding “Beliefs about health and illness in Swedish and African-born women with gestational diabetes living in Sweden”. The study compared 23 patients with gestational diabetes, where 10 women were born In Africa and 13 were born in Sweden, to explore the effects of culturally related health/illness beliefs on their health. Migrant women, especially of African origin, have a higher risk of developing gestational diabetes than women born in western countries. The results found that the differences in health beliefs had significant effects related to care-seeking and self-care. Beliefs about health and illness are related to the person's knowledge. African born women had a lack of awareness about their bodies and diabetes. They showed a lack of knowledge about the cause of gestational diabetes. They believed that the pregnancy is something normal and the information about GD is just amplified by healthcare providers. The study recommended that patients' beliefs and their risk awareness are important in clinical practice (Hjelmet al., 2012).

Another study conducted by Lorna Bartram in Sweden to investigate which situations Arabic-speaking and Swedish-speaking people experience language barriers, and Which words and phrases are most common in these situations. She used qualitative surveys at two multilingual facilities: a hospital in an immigrant populated area and accommodation for unaccompanied minors. She compared the collected vocabulary from the surveys with vocabulary lists from Tawasol Symbols

(the first research project focused on AKK - Alternative and Complementary Communication for Arabic speakers and is the result of an interdisciplinary collaboration between researchers from the UK and Qatar), and The KELLY list (a corpus-based dictionary intended for second language learning in nine different languages). The results indicated there are three situations where Arabic- and Swedish speaking people experience language barriers; Examination and Surgery, Booking and Administration, and Transit. The comparison with the two vocabulary lists founded the greatest overlap with The KELLY list. The study assures besides the need for terminology and instructions regard to transactional issues in communication, there was a need for socially oriented or interactional communication (Bartram, 2016).

6. Method

In this section, I will present the empirical material that was collected in order to answer the problem formulation and achieve the purpose.

6.1 Study design

The study is a qualitative method, since it is based on the parties' experiences and trials in their respective working lives. According to Dalen (2008) in her book *Intervju som metod* (interview as a method), the qualitative research interview tries to understand the world from the participant's point of view, formulate the meaning of the interviewee's experiences and bring out their conception of life, before embarking on scientific explanations (Dalen, 2008: 11-13). Questions regarding the perception of and thoughts on a phenomenon are best answered through a qualitative study with an inductive approach (Kristensson, 2014: 36).

An interview study with a qualitative design was chosen as the method of this study. The purpose was to study people's experiences of the phenomenon of cultural clash in health conceptions between two cultures, which is a foundation in a qualitative design. I assessed that it would be more efficient and more significant in terms of results than if I had used quantitative methods, because my target was people's experience and not to quantify results. The interview method that I used was semi-

structured interviews with open-ended questions. This is the most common form of the method used in culture-healthcare-related studies. The cultural norms and ideas do not change from one day to another, but the process of change goes on for a long period of time. This suggests that if this study was to be done again within a short period of time, the results would probably be similar.

The questions were created based on my interpretation of the literature study to seek answers to what extent culture and language play a role in communication with Arabic speaking patients. The study's goal was to examine the cultural and linguistic aspects that affect communication with healthcare providers through the eye of the microculture individuals, as well as get inspiration for solutions that may lead to better communication with the microculture individuals. I made several visits to Arabic associations and meeting places, where I asked people about their attitudes towards the Swedish healthcare system and about the challenges they were facing. After that, I tried to evolve their point of view in the interview questions to get a better understanding of those aspects, seen through the eyes of professionals in their position at the border between the macro- and micro-cultures.

A pilot interview was conducted to evaluate the interview guide and test the recording equipment and my role as an interviewer. The test led to a change in the selection criteria and adjustment of the interview guide. The interviewer spoke both languages (Arabic and Swedish) fluently and the interview was thus conducted in Swedish. The participants had different experiences in Sweden and spoke different levels of Swedish. An assessment was then made that the linguistic misunderstandings would decrease if both were to speak the same language. The informant on this occasion was assessed to speak and understand an advanced level of Swedish, that would answer the purpose. However, the interviewer chose to conduct the interviews in Arabic (which is the mother tongue for both the interviewer and the participants) to avoid the misunderstandings that may occur when the participant doesn't speak the required level of Swedish, as well as to create more space to discuss the dialect issues.

Before the start of the interviews, the informants were given information that they could interrupt and pause the interview without having to state any reason. They were also given information about the study's purpose, structure, and what it means to participate. In this way, informed consent was sought. Because of the sensitive nature of the healthcare providers' and interpreters' work, in combination with the Public Access to Information and Secrecy Act, the participant asked for

questions before the interviews. Questions were not related to a particular case or asked for the personal information of either participants and patients.

The interview guide started with introductory questions, followed by open-ended questions. These were in turn followed by follow-up questions. Using the interview guide kept the interview format free, yet at the same time tight with regards to the essential questions. The benefits of this semi-structured interview method were that it allowed the interviewer to adapt to what came up in the interview and encourage the informants to share their answers and experiences of the informants. However, there are also several limitations in semi-structured interviews, that must be taken into account during analysis. This places responsibility on the interviewer to be neutral and not influence the answers in a certain direction. There is always a risk that the frame of reference of the individual and the effort to admit the different reasoning of the participant could contribute to the answers becoming unknowingly influenced in such a way as to support the hypotheses already established. Another limitation is the challenge in comparing the responses of the different participants, since the follow-up questions vary with each interview. This implies that the generalization sometimes can be limited based on individual cases (Dalen, 2008: 115).

During the interviews, care was taken to stay within the framework of the questions. Personal events that had nothing to do with the research were not further developed, in order to respect and maintain the informants' integrity. The interviewer grew up in the Arab culture, so she was well aware of the verbal and non-verbal factors that could lead to misunderstandings during the interview. Doulas interviews were conducted in their working place, but interviews with the physicians and interpreters were conducted over the telephone.

6.1.1 Selection

The first step in the selection was to find participants with a potentially high level of information on the subject, which can maximize the understanding of the phenomenon. The chosen participants were from different Arabic countries, speaking different dialects, and had different educational backgrounds inside and outside of Sweden. The goal was to find a group of Arabic-speaking participants who live in Sweden and represent the diversity of microculture individuals.

According to Dalen (2008), the choice of informants in qualitative interview research is a particularly important issue. Who should be interviewed, what selection criteria are used, and how many? It is agreed that the number of informants cannot be too large, as both the interview process and the interview analysis are time-consuming processes. At the same time, the interview material collected must be of such quality that it constitutes an adequate basis for interpretation and analysis (Dalen 2008: 27-29, 38)

There were three different groups: interpreters, physicians, and doula/cultural interpreters. The interpreters and physician participants were identified with the help of "snowball selection" by recommendations from the authors' friends. The advantage of this is that it is quick to find new persons for the selection, because each person recommends two or more new ones. It may also be easier to convince new people to participate in the study when they have been recommended by an acquaintance. I visited a Swedish hospital to inform the participants of the study's purpose, structure, and what it means to participate in oral form. Many Arabic-speaking physicians were working in this hospital. Every physician got the approval to participate in the study from his/her head of department.

To find interpreter participants, I contacted my former classmate in the interpreter training class of 2017. That class was held in Åsa folkhögskola near Stockholm city, but the participants of my study came from all over Sweden. About 10 persons where been contacted and 4 of them accepted to participate. One of them works as a freelancer and one works in a private interpreting center. The third one works as a nurse and studied interpreting at the request of the health center where she works, since they have had many immigrant patients. The last one did not finish the course, yet worked extra as an interpreter.

To find doula and cultural interpreter participants, I contacted the manager of Early Parental Support (Tidigt föräldrastöd association) in an area where the majority of immigrants in Gothenburg city live. The association develops activities and projects that contribute to equality in health and a good start on parenthood and the child's life. It focuses on families and mothers with special needs for social networks, integration help, or support in difficult situations. There were 4 participants; 3 of them were doulas while the fourth was only a cultural interpreter. The interviews were conducted in the same center. In table (1) all participants' information can be found:

Table (1): participants information

profession	Country of origin	Older	Gender	Residence in Sweden (years)	Work experience in Sweden in current profession (years)	Education
Specialist physician	Syria	36	Male	6	5	Specialist in Syria + under specialty training (postgraduate training) in Sweden
Internship physician	Syria	31	Male	6	3	In Syria + knowledge tests for foreign physicians in Sweden
Residence physician	Syria	36	Male	6	4	In Ukraine + The program for supplementary education for doctors with a foreign degree/ Gothenburg university (one year)
Residence physician	Iraq	38	Male	4	3	In Iraq + under specialty training (postgraduate training) in Sweden
Interpreter	Iraq	50	Female	25	4	Basic interpreter training
Interpreter	Palestine	47	Female	10	7	Basic interpreter training
Interpreter	Iraq	50	Female	12	3	Basic interpreter training
Interpreter	Syria	27	Female	8	1	Uncompleted basic interpreter training
Cultural interpreter	Iraq	59	Female	8	2	Doesn’t have an education in Sweden
Doula and cultural interpreter	Iraq	43	Female	16	11	Doula and cultural interpreter training
Doula and cultural interpreter	Iraq	37	Female	15	4	Doula and cultural interpreter training
Doula and cultural interpreter	Iraq	33	Female	25	3	Doula and cultural interpreter training

6.1.2 Research ethics considerations

Before starting the interviews, information regarding the study's purpose, structure, and what it means to participate was given to the informants. The informants were informed that they could interrupt and pause the interview without having to state any reasons. In this way, informed consent was sought. Because of the sensitive nature of the healthcare providers' and interpreters' work, as well as the Public Access to Information and Secrecy Act, extra considerations have been taken. The information letter sent to department heads was designed according to Sandman and Kjellström (2013). Information on how collected material was to be processed, stored, and handled was also provided to the participants. In the design of the introductory letter, I strived to give a clear and concise presentation of the purpose of the study and how the respondents' answers would be used. I also attached my contact details if any of the respondents would like further information about the survey (Sandman and Kjellström, 2013:387-390). The

The interviews lasted between 13 and 40 minutes and were recorded with a password protected mobile phone in flight mode. The recorded interviews were saved on a password-protected computer. During transcription, the interview was deidentified to ensure that the material was treated confidentially. The material was kept inaccessible to unauthorized persons and was used only for the study in question. After the study is completed, all interviews will be deleted (Sandman & Kjellström, 2013, 391).

6.1.3 Processing and analysis

The collected data was processed using qualitative content analysis. The first step in processing was transcribing all the interviews. Transcribing means writing down the interviews word for word into a long text. I had the support notes I wrote during the interview in front of me while listening to the audio recordings. Transcribing took quite a long time as especially two of the interviews were very long. The interviews were read through several times to enable a grasp of the entire text. After that, a more accurate reading was made. Meaning-bearing units, consisting of sentences and phrases

relevant to the purpose of this study, were identified. These units were then condensed to make the text shorter while still retaining the important content. Based on this, codes were created that described the content of the sentence. The codes were compared with each other and those that were the same were sorted into the same category. These categories showed the main messages in the interviews.

7.Results

This chapter presents the material from the interviews with the 12 participants. The results of the study report the conditions for a patient who has insufficient or no knowledge of Swedish as they seek care, as well as other who speak Swedish but still have communication problems. The chapter is structured in such a way that the informants' answers have been categorized into themes that were created in advance through the interview guide. These themes are:

- Cultural and systemic differences that lead to misunderstandings.
- Health culture of Arabic speakers, and the way it collides with the Swedish health culture according to Arabic-speaking professionals.
- The linguistics and dialect aspects, and how to overcome dialect differences.
- Suggested solutions that may lead to better intercultural communication in the context of health.

Under each theme, subheadings have been created to summarize and delineate the most central themes. Quotes from the interviews are used throughout to exemplify, clarify, and summarize the participants' experiences linked to the different themes and categories.

During the interview analysis, another theme emerged through the interviews:

- Since the cultural interpreters could build a relationship with the patient which led to a deeper understanding of the patients' culture and terminology, they could produce a kind of adapted translation which was more correspondent to the character of the patient and more specific about what the patient felt (as they described it).
- Cultural interpreters could also build trust with the patients, which led to patients expressing their real struggle with the sickness without exaggeration. That helped the communication between the doctor and the patient and made it more specific and authentic.
- The interpreter's word by word translation is sometimes ineffective and insufficient to transfer the feelings of the patients to the doctor, and the interpreter feels unauthorized to intervene if he/she feels that the patient did not understand what the doctor was trying to say.
- The new migrant generation (arriving in the last 10 years) has a higher health awareness, and is more willing to learn about the Swedish healthcare system. Some of them even adopted the Swedish health mentality and integrated it into their lives.

7.1 Differences lead to misunderstanding and culture conflict

- When asking about the differences in health and treatment concepts between the Arab countries and Sweden, all participants unanimously pointed out that the Swedish health care system depends on the body's response to heal itself and postpones the surgical and other treatment methods to the last stage. In Arab countries, medical intervention, in all its forms, starts directly in the first meeting. This is something that often leads to a kind of culture clash in the health care context.

  > "The biggest difference between the Swedish health system and the health care system in our country is the delay of dispensing medication and surgical intervention to let the body heal itself, encourage the immune system and physical treatment" Naim

  The issue makes Arab patients raise their eyebrows and interpret it as they just have Alvedon (Paracetamol) and water as an exclusive treatment.

  > "The Arab patient is always surprised by the treatment method by saying they just give an Alvedon and recommend us to drink water". Abeer

  Therefore, the patient finds no incentives to follow long-term medical advice and recommendations, such as rehabilitation and physical therapy.

  > "The Arab patient finds difficulty in accepting the treatment period and physical treatment. In comparison, the Swedish patient accepts the long-term treatment until results appear". Anas

- The Swedish health system is radically different from the Arab health care system in the way of providing the required care. It is divided into two lines; primary care and advanced care. In most cases, primary care cannot be neglected to reach advanced once.

  > "As the Arab patients have medical issues, they expect to meet the specialist directly and when meeting the desired physician, they have high expectations that the problem will be solved. In Sweden, the process of treatment starts in the primary care units, in case of need for advanced consultation, the case will be

> referred to the specialist. Arab patients prefer always to seek advance help immediately". Zaid

This disappoints Arab patients, as they used to seek help directly from the specialist, i.e. advanced help and treatment. This has led, sometimes, to the patients exaggerating and amplifying the signs and symptoms to demonstrate that it is urgent and needs immediate medical intervention to speed up the medical process.

> "The Arab patient is used to, from the first doctor appointment, to get an x-ray, lab tests, and treatment, and this thing cannot be found here in Sweden. This makes the Arab patient exaggerate the symptoms to pretend that his case is urgent to get what is desired". Anas

- The second difference in treatment concepts is that the medical decisions are up to the patient itself (surgeries, vaccinations, and therapies).

> "Here in Sweden the patient has the right to decide the treatment method, but in our countries, we are not used to doing that. We always receive and obey what the doctor says. E.g. when the doctor is asking the patient if he/she wants to do the surgery, which confuses the patient". Liqaa

This dissatisfies the patients, causes confusion and affects the patient's trust in the doctor and the whole medical health system in a major way.

- The nurse's role and power in the Swedish health system are totally different, as they can make decisions in the treatment process and prescribe medication, whereas in most of the Arab countries they are assistants and follow medical orders. This makes the patient unsure of if they should follow the instructions and makes the health care professionals' roles unclear.

> "As an example, one of the patients was determined that the nurse is a doctor and is treating the patient because she wears white. Most of them, about 60-70%, call the nurse a doctor since the nurse in our countries does not wear it here as a doctor and takes many responsibilities". Rafif

- The physicians in the Arab world are well educated and have a high societal status. That is why there is a common stereotype about physicians. They have long educational periods, so, logically, they must have enough knowledge to know about medical issues. Sometimes in Sweden, physicians, during the appointment with patients, use aids as books and website sources to reach the best treatment methods for patients. In the eyes of Arab patients, this indicates the doctor's lack of knowledge in treating diseases.

  > "When the doctor says, just give a moment to check on the internet or like reading a medical book, the patient becomes surprised and asks himself if the person he is meeting is a qualified and knowledgeable doctor?" Ghada

- A lack of awareness of systemic issues and details related to the working mechanism of the Swedish health care system may be interpreted as lack of interest or lead to misunderstanding and lack of trust between the two parties. Physicians in Arab countries have nothing to do with documentation and administrative work. They usually gave instructions orally and let the nurses do all the instructions. In this way, they have enough time to discuss with the patient and the ability to meet a large number of patients. In contrast, Swedish physicians have to perform more tasks and have limited time.

  > "The physician has limited time to perform various duties, such as taking a history, performing a physical examination, ordering lab tests, prescribing medication, explaining the findings and treatment, dictating or writing the detailed appointment, etc. Those duties, regardless of meeting Swedish and Arabic health care providers, take time and however take longer in meeting an Arab patient to explain from the basics and to build and bind everything together to make it more understandable and reliable. Besides that, using an interpreter to translate the appointment will make it worse and more stressful for both parties and this leads to lower communication and treatment quality. The health system is based on an analytical statistical mindset. As about 70% of physicians time is administrative and 30% is practical". Sulaiman

7.2 Health culture of Arabic speakers and its problematics according to Arabic professionals

- Arab patients are usually vague in describing the symptoms, using open words like “I have pain”, but what kind/type of pain? In the Swedish language, there are specific words to precisely illustrate the pain character (dullness, numbness, etc.). This in general is not used by Arab patients, who make a vague description of symptoms to the Swedish care providers.

> “In case of meeting an Arab physician diminishes the language barriers and becomes easy to describe the symptoms freely as they understand each other. But in case of meeting a Swedish doctor, the translator is translating the exact words as it is, so in these cases, the whole meaning loses its purpose and meaning and the words become meaningless”. Sulaiman

- There is a lack of health awareness and accuracy in dealing with medicines. Some Arab patients are not used to reading about their illnesses. Sometimes, they hear from others, like relatives and friends, about their experiences in treating the same disease/symptom and sometimes use the same medication/therapy before seeking medical help. In Sweden, there are strict regulations that control and restrict treatment methods and modalities. This can affect the desired quality of the “primary” treatment method and make it harder for the healthcare provider to give the patient the correct and effective treatment.

> “Some Arab patients do not read about their illness and are not interested in reading the website 1177 to know more about illnesses and its common treatment methods”. Liqaa
>
> “There is a difference in health awareness and there are many factors that influence health information such as friends' and relatives’ opinions and experiences using medicines that have helped them. These health habits can make the case worse or lead to false medical assessment”. Naim

- Prevailing ideas in Arab societies, e.g. that the long-term use of medicines can cause addiction, as

well as lack of knowledge of common illnesses and lack of treatment compliance despite the importance of treatment, e.g. lifelong insulin treatment. This kind of health culture idea can be life threatening and need Swedish healthcare providers to put more effort into focusing and following up on different cases.

> "In my eyes, I can see that health awareness is very low, e.g. diabetes, as this illness is very common and has many chronic complications. As simple as, the Arab patient, stops taking insulin when the blood sugar level is getting better as assuming the medication insulin is addictive". Abeer

- In the Arab culture there is a kind of stigma and non-acceptance of psychological/mental illnesses. There is also a lack of knowledge of treatment methods and the possibility of improvement. This kind of belief can affect the wellness of Arab community individuals.

> "Lack of awareness about mental illnesses as a real dimension and has treatment with improvement potentials". Naim

- The patient carries negative preconceptions to the healthcare providers and the system. There is a feeling of neglect as a consequence of the long wait to meet the healthcare provider, compared to the previous medical services in their home countries, with its privilege to meet or get rapid medical attention.

> "The communication with Arab patients is a little bit more challenging because of the dominant prejudices on the way of treatment they used to get in their motherland. Since they get therapy and diagnosis from the first meeting. While it differs here in Sweden in the treatment sequence. The patient comes to the appointment with a negative impression in advance. Like expecting the doctor will not send a transfer to x-ray, will not get any medication, etc.". Anas

> "The difficulty of getting an appointment with the healthcare provider poses a negative reaction in advance since the patient has suffered to get this appointment". Liqaa

- The refusal of care from the opposite gender when it comes to reproductive and sexual diseases is the result of sensitivity on this point in the Arab culture.

> "I was an interpreter to a male patient. He had problems with the reproductive system, he refused totally to explain to any female his problem and begged to get a male interpreter despite my explanation about the duty of confidentiality". Abeer

> "There is a female patient who lost her appointment with a gynecologist. When she met the doctor, which was a male physician, she refused to get examined because he was of the opposite sex". Shilah.

7.3 The language and dialects

In questions regarding the dialect differences for Arabic speakers, all participants emphasize the effect of this difference on the extent of communication with Arab patients. On the other hand, they also emphasize that those effects can be solved and avoided by using several strategies and techniques:

- Questioning about strange words and memorizing those to be used on other occasions.

> "Interested and well-read health care providers could surpass dialect matters because strange words are easy to remember, and pass them each time". Zaid

- Simplifying the spoken words using a "simple version" or "hybrid dialect" to avoid misunderstandings.

> "I am from Iraq. I changed my accent to Syrian accent due to the countless Syrian who came to this country in 2017, many have requested from me to simplify my words when I express myself because many words could not be understood. With other nationalities I use a hybrid accent which is mostly incomprehensible for many". Roua

- Reading and learning about the cultures and habits of the speakers of other dialects.

> "At the beginning, it was quite challenging to interact with Syrians because we do not share the same accent but through the time I have read about the Syrian culture, food and habits then it became easier". Rafif

- Trying to articulate in easier sentences. Repeating sentences and asking the patient to confirm what they intended to say.

> "The moments I sense any difficulty to understand the accent, I immediately request repetition of what it has been said or I ask do you mean that or this until I am completely certain". Abeer

- Using the standard Arabic language in case of difficulty with communicating in colloquial Arabic dialect. Especially when dealing with Arabs from the North African countries who have a significantly different dialect mixed with French words.

> "The Moroccan accent is really difficult to understand, many French words are being blinded in, more often I use standard Arabic (fuṣḥā) accents instead". Roua

- Using an interpreter in case of difficulties to adapt or simplify the spoken accent to make it easier and understandable to both parties.

> "Many Arab physicians are using interpreters with some patients who speak other Arabic accents due to lack of adaptation between them with their accents, some scientific expressions, name of body parts, and different names of diseases have different names in many countries". Sulaiman

7.4 Recommendations

I asked the participants about suggestions that may facilitate approximating the perspectives and minimizing the health cultural conflict and therefore better improve cultural communication. Additionally, I asked them about the importance of creating educational courses, workshops or educational videos that explain how the Swedish health system and its philosophy works, as well as clarify the patient rights and obligations in this system. All the participants emphasize the importance of those suggestions and subsequently their contribution to resolving the clash between health cultures and easing the matters between the two parties.

- Provide lectures and educational courses that can explain to the newcomer the mechanism and how the Swedish healthcare works, as well as the sequence of treatment. They could preferably be part of the language and community courses, and be in batches since all this information could make it difficult for a newcomer to understand and memorize the information.

> "Courses are super important; it makes our business smoother. Much information in Arabic exists on several websites, unfortunately, it does not reach all society segments or it requires more practice and exercise or intermediary (culture interpreters) such as us as an assistant to be asked if necessary". Rafif

> "Such hypotheses and suggestions are useful and subjective but considering some society segments that are isolated from the Swedish society such as mothers who gave birth to many newborn kids and have a long parenting period at home. Organizations such as ours are also very helpful, we provide support to over 300 mothers". Hiba

- Educate health care providers about these groups of patients to make them easier to understand and treat.

> "Educating the medical staff about communication and interacting with various ethnic groups and how they express themselves and why they use particular ways of interaction". Sulaiman

- Part of the responsibility falls on the newcomers to learn the language and to educate themselves about the new country and its health system.

> "Courses are incredibly an important idea and there is a duty on every newcomer to learn the language. If the newcomer refuses to learn the language however then they should accept receiving a lower quality of services". Zaid

- Educating interpreters and setting higher standards for their employment.

> "Higher standards should be taken into consideration when it comes down to using interpreters and they should be well trained" Naim

8. Discussion

8.1 Method discussion

The study method was a qualitative interview study. The author believes this method was appropriate, both in terms of subject choice and how the purpose of the study would be fulfilled. Dalen (2008) points out that with a qualitative method, we seek understanding and insight rather than facts.

The purpose was to examine the experiences and points of view of a specifically selected group. A quantitative method, such as a survey, requires a larger number of participants and it is difficult to give an equally broad picture of individual experiences. Using interviews as data made it easier for the author to get an overview of the informants' experiences of two health cultures when meeting Arabic speaking patients.

All informants were born in Arab countries (Syria, Iraq, Palestine) and speak Arabic as their mother tongue with different dialects. 11 of 12 participants have a Swedish education or passed Swedish exams to work officially in Sweden. 10 of 12 participants worked for several years in their country of origin. Even if they met the selection criteria, a broader selected group could have given a broader result, for example with informants who speak Arabic as a second language, or physicians who worked for a long time in Sweden.

The study included twelve interviews in three groups, with four participants in each group. More interviews might have given broader results. I felt that the views were recurring and saw a pattern in the twelve interviews that formed the basis for the results. The material provided by the interviews was considered sufficient to fulfill the purpose of this study. Too many interviews could result in an unmanageable load of material (Dalen, 2008: 29-30). The same interview guide was used in all interviews, which gave the study a unity and homogeneity.

According to Kristensson (2014), the author's presence at all stages of the study will strengthen the reliability of the study. But the fact that only one author was present during the interviews, will lower

its reliability (Kristensson, 2014:139). On the other hand, the author believes that credibility increases when the same person who conducted the interviews translates the text, without the involvement of an interpreter. The interviewer has Arabic as a mother tongue and was able to understand verbal and nonverbal aspects. The author was one of the newcomers in 2013 and has experienced the culture clash in the field of healthcare herself. She was a university teacher in the language and culture department. In addition, she is an educated interpreter in Sweden, and so has academic knowledge and personal experience regarding the linguistic and cultural aspects of intercultural communication. She also studied two educational terms in occupational therapy at Örebro University, giving her academic knowledge of the Swedish health care system. This is one of the strengths of the study, since it may have made it easier for the interview participants to openly answer the questions and tell about their experiences. However, the credibility of the results may due to the same aspect have been negatively affected, as the results may have been shaped by the authors' preconception. Furthermore, the semi-structured nature of the interviews had open-ended questions, which were not leading the informants but instead gave them space to freely tell and reflect on their experiences. The result can, therefore, be assumed to be credible.

All collected data were analyzed and interpreted on the basis of a proven scientific content analysis, which can be assumed to have minimized the risk of misinterpretations in the results and which thus increases the reliability of the results. The use of voice recording may have strengthened the result as all statements could be transcribed and made available for analysis. The participants have been contacted during the analysis for further understanding when there were several possible explanations of the analysis data.

8.2 Study discussion

The study aims to investigate intercultural communication in the context of healthcare between Arabic speakers in Sweden as a microculture and the Swedish healthcare system as a macroculture. The surprising increase of immigrants' numbers after the last tensions in Syria and Iraq contributed to making the Arabic speakers a huge minority group in Sweden. According to the Swedish statistics, Arabic is now Sweden's second most common mother tongue. The Arabic language is spoken in 23 countries, so the Arabic speakers in Sweden have different cultures and different dialects. On the other hand, the number of Arabic speakers employed in the Swedish healthcare system has increased. All these factors have made the study of intercultural communication in Sweden important.

The study method was semi-structured interviews with open-ended questions and was conducted by interviewing three groups of professionals: Arabic speaking healthcare professionals in different Swedish workplaces, doula/cultural interpreters, and oral interpreters. Each group consisted of four professionals.

The results find that differences in culture impact the patient's perception of the healthcare system, its management, and the general ways to cope with illnesses through prescriptions, treatments, and diagnosis.

Patients and their families bring their cultural concepts and values regarding health, illness, the description of symptoms, and a set of medical care expectations, as well as ideas for treatment and medication. Moreover, cultural values impact the roles and expectations of patients, data on diseases and treatment, death, patterns of bereavement, gender norms and family roles, as well as decision-making processes

The results were grouped into four themes:
1-The results showed that the differences in the healthcare systems in Sweden and the Arab world have significant effects on the Arabic speakers' health and understanding of the healthcare system in Sweden.

There are differences in treatment concepts between the Arab world and the Swedish health care system which emphasizes the capacity of the body's immune system to heal itself. This delays the medical and surgical interventions until a late stage, which is the contrary to the Arab world health care procedures, where medical and surgical interventions are conducted as a first step. This leads to Arab patients in Sweden questioning the healthcare system's legitimacy and distrusting it. It also leads to patients losing interest in continuing long-term treatments as they expect a quick fix.
The Swedish healthcare system has two lines of support that need to be followed in order, the primary line and the devices line. In contrast, the Arab healthcare system has one line, which is advanced. This leads to Arab patients getting disappointed when they can't meet a specialist right away, so they can exaggerate their symptoms thinking that this will make them see the specialist faster. This could lead to wrong treatments.

There is a stereotypical view of the doctor and the nurse in the Arab world, that a doctor is a well-educated person that has all the information. In the case of Swedish doctors looking something up in the system, the patient interprets it as a lack of qualification. Nurses in Sweden also have more authority to prescribe certain medicines and to give advice, whereas in the Arab world nurses are just following the doctor's instructions. This could lead to Arab patients mistrusting and not following the nurse's instructions.

In Sweden, the decision on medical procedure is left to the patient, after the doctor has explained the case and the options. Instead, the Arab patient expects the doctor to make the decisions, and when they are being asked to make the decision, they interpret it as the Swedish doctor being underqualified.

1- Health culture of Arabic speakers and its problematics according to Arabic speaking professionals

Arab patients are vague in describing their symptoms to the doctor, which leads to miscommunication between the doctor and the patient.
There is a lack of awareness of the need for preciseness in dealing with medicine. Arab patients may listen to similar experiences from friends and family and decide to use medicine without consulting the doctor. That affects the quality of the treatment offered by the Swedish doctor and could lead to misinterpretation of the symptoms of their sickness.

There is a cultural belief among Arab patients that long-term medication could cause addiction, leading them to misuse it and sometimes not use it at all, which could lead to bad consequences for their treatment.

Arab patients have a huge stigma when it comes to mental unhealth and refuse to admit its existence. This affects the wellbeing and health of the community members. Arab patients may refuse medical help offered by physicians from the opposite gender regarding sexual diseases.

3-The language and dialects:

The differences in dialects may affect the quality of the communication between the Arab professional and the Arab patient. However, the Arab professionals have developed new techniques to solve this issue, by learning new terminology and making sure the patient understands and confirms what they say more than one time. The professionals sometimes use simplified terminology to make the patient understand what they mean. They also read about the different Arab countries' cultures and habits so they can adapt their communication to that level. When they face a challenge to communicate in modern Arabic, they also use the written formal Arabic (a common language shared by all Arab countries) to communicate. When they fail to communicate in a good way, they also use interpreters to help them with the communication.

4-Recomendations

To educate the newcomers during SFI (Swedish for immigrants) courses on how the Swedish healthcare works and the sequence of treatment.
To educate health care providers on the cultural differences they may encounter while providing service to Arabic speaking patients.

To raise the question of the newcomers' responsibility to learn the language and educate themselves with regards to the new country and its healthcare system, after giving them access to the necessary information.

Educating interpreters and setting higher standards for their employment.

9. Conclusion

Differences in culture of health and healthcare systems between the Arab world and Sweden, rise challenges to healthcare delivery and access. Arabic speaking peoples do differ ethnically, but they still have shared beliefs and behavior. The challenges they facing, are more than linguistics issues, it is often strained by invisible intercultural misunderstanding as well as linguistic and communicative destitution. Healthcare professionals need a better understanding about the diverse beliefs and patient expectations, as well as knowledge about inclinations of the social cultures. It requires to supply enough information and intercultural understanding to provide a comprehensive equal healthcare.

10. Further research

To gain a greater insight into how cultural conceptions about health and healthcare systems affect immigrant patients' health, a study from the patients' perspective may be relevant to see if the interpretation of the results is the same. This would show if our understanding has influenced our interpretation of the study. The physician's participants in my study are all newcomers, they spend less than 6 years in Sweden. Interviews with participants with long staying in Sweden and with long years of experience may give a deeper analysis of the situation in a bigger frame. 6 of 8 of the interpreter's participants were educated and qualified, this may affect the results because they don't reflect the real situation regarding using interpreters in healthcare. The previous researches report that using unqualified and non-educated interpreters raises many communication difficulties, as it points to communication challenges and translation errors caused by the differences in Arabic dialects, and interpreters' lack of knowledge of medical terminology. The interpreters in my study indicated that these issues are solved and their effects are slight. More practical experience for the author is needed, for a better knowledge about healthcare system's protocols and laws, as well as for a deeper research analysis.

To gain a further understanding of the impact of cultures on organizational culture, a future study may include only leadership, to examine its importance in influencing organizational culture in general. More research can lead to a better user experience for Arabic speaking patients while dealing with the Swedish health care system.

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12. APPENDIX

12.1. Etiska överväganden (Ethical considerations)

Hej!

Mitt namn är Hiba Al Abdallah, jag är student på Göteborg universitet där jag studerar språk och interkulturell kommunikation. Jag skriver nu min magisteruppsats om micro kulturell kommunikation på arabiska inom svenskt hälso-och sjukvårdssystemet, genom att intervjua arabisktalande sjukvårdspersonal på olika arbetsplatser i Sverige, tolkar och doula-kulturtolkar. Syftet med undersökningen är att undersöka de kulturella och språkliga aspekterna av att kommunicera på arabiska när de tillhandahåller sina professionella tjänster till arabisktalande patienter. Och för att upptäcka hälsokulturkrock mellan arabisktalande kultur och svenska kultur.

Varje intervju kommer att ta cirka 15–20 minuter. Jag garanterar deltagande ska bli anonyma, och att de inte kommer att kunna identifieras. Jag kommer att bekräfta information med deltagarna. Därefter, kommer jag att spela in intervjuer, och det insamlade material kommer enbart att användas för min egen forskning. Det är frivilligt att delta i denna undersökning, och det är möjligt till deltagaren att när som helst avbryta intervju utan behov till förklaring. I slutet av varje intervju kommer jag att fråga intervjuade om det är något den önskar tillägga eller ta bort. Efter att varje inspelning transkriberas kommer materialet att förstöras. När magisteruppsatsen är färdigt kommer den att skickas till Göteborg Universitet, där alla undersöknings kan läsa uppsatsen vid intresse.

Jag skickar frågorna som kommer att ställas under intervjun, så att deltagarna kan läsa dem innan intervju. Finns det några frågor kring intervjun eller min magisteruppsats får ni mer än gärna höra av er till mig.

Tack för din medverkan! Vänliga hälsningar,
Hiba Al Abdallah

12.2 Interview guide

How old are you?
How many years have you lived in Sweden?

How many years have you worked as a physician/interpreter/doula? Do you have an education from Sweden?
How do cultural differences between the Swedish health system and the health systems in the Arab world affect communication with the Arab patient?

Which problems are you facing/noticing with Arabic speaking patients that are related to their culture and affect communication in the meetings?

Many Arab patients are dissatisfied with the Swedish medical method and prefer to meet an Arab physician instead, is that related to the lack of trust? If yes, what are the reasons for the lack of trust in the Swedish health system among Arab patients?

To compare between the newcomer and the person who moved to Sweden for several years, have you noticed a change or development in the attitude towards the Swedish health system, or better understanding of its treatment method?

Does the different dialects and cultures of Arabic speakers affect communication with the patient (Iraqi - Moroccan – Syrian..)? What are the dialects that find it difficult to understand some of her words? Or do you face challenges communicating with its speakers?

What do you do when you think that there is misunderstanding or miscommunication with patients who speak different dialects?

Do you think that creating educational courses, workshops, or video clips for Arab patients for the purpose of explaining the Swedish healthcare mechanism, and what are the patient's rights and obligations in this system, can contribute to solving these problems? Do you have other suggestions?